# Complete Summary

## GUIDELINE TITLE

Identifying and treating eating disorders.

## BIBLIOGRAPHIC SOURCE(S)

Identifying and treating eating disorders. Pediatrics 2003 Jan;111(1):204-11. [78 references]

## COMPLETE SUMMARY CONTENT



## SCOPE

### DISEASE/CONDITION(S)

Eating disorders, specifically, according to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed (DSM-IV), anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified.

### GUIDELINE CATEGORY

Evaluation
Management
Prevention
Screening
Treatment

### CLINICAL SPECIALTY

Family Practice
Nutrition
Pediatrics
Psychiatry
Psychology

## INTENDED USERS

Health Care Providers
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

## GUIDELINE OBJECTIVE(S)

- To assist pediatricians with early detection and appropriate management of eating disorders
- To prevent the physical and psychological consequences of malnutrition that allow for progression to a later stage of an eating disorder

## TARGET POPULATION

Children and adolescents

## INTERVENTIONS AND PRACTICES CONSIDERED

### Screening, Assessment and Diagnosis

1. Initial evaluations
    - Patient history, including screening questions about eating patterns and satisfaction with body appearance
    - Medical status
    - Nutritional status
    - Psychosocial status
2. Physical exam
    - Weight and height measurements plotted on pediatric growth charts
    - Body mass index (BMI)
    - Establishment of the diagnosis along with a determination of eating disorder severity
3. Laboratory tests
    - Initial laboratory tests (complete blood cell count, electrolyte measurement, liver function tests, urinalysis, and a thyroid-stimulating hormone test)
    - Additional tests (urine pregnancy, luteinizing and follicle-stimulating hormone, prolactin, and estradiol tests) in patients who are amenorrheic
    - Other tests, including an erythrocyte sedimentation rate and radiographic studies (such as computed tomography or magnetic resonance imaging of the brain or upper or lower gastrointestinal system studies), if there are uncertainties about the diagnosis
    - An electrocardiogram in patients with bradycardia or electrolyte abnormalities
    - Bone densitometry in those amenorrheic for more than 6 to 12 months

### Treatment/Management

1. Nutritional counseling

2. Establishment of treatment goal weights, based on age, height, stage of puberty, premorbid weight, and previous growth charts
3. Reintroduction or improvement of meals and snacks (in those with anorexia nervosa) in a stepwise manner
4. Psychosocial counseling, including individual, group, and/or family therapies
5. Management of medical sequela
6. Reevaluation of goal weights at 3- to 6-month intervals for growing children or adolescents
7. Behavioral interventions to encourage necessary caloric intake and weight gain goals
8. Psychotropic medications, e.g., antidepressants, if indicated
9. Referral to subspecialties, e.g., nutrition, psychiatry, psychology, gastroenterology, cardiology, endocrinology, neurology, dentistry
10. Inpatient, multidisciplinary hospitalization, day program treatment, or intensive outpatient program treatment for medical stabilization and nutritional rehabilitation, including enteral (nasogastric tube feedings) or parenteral (intravenous) nutrition
11. Eating disorders prevention, education, and screening at family, school, and community-wide levels

### MAJOR OUTCOMES CONSIDERED

- Prevalence and incidence of eating disorders in children and adolescents
- Medical complications of eating disorders
- Relapse rates
- Malnutrition sequela

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

### METHODS USED TO ANALYZE THE EVIDENCE

Review

### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

### COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

### METHOD OF GUIDELINE VALIDATION

Peer Review

### DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

1. Pediatricians need to be knowledgeable about the early signs and symptoms of disordered eating and other related behaviors.
2. Pediatricians should be aware of the careful balance that needs to be in place to decrease the growing prevalence of eating disorders in children and adolescents. When counseling children on risk of obesity and healthy eating, care needs to be taken not to foster overaggressive dieting and to help children and adolescents build self-esteem while still addressing weight concerns.
3. Pediatricians should be familiar with the screening and counseling guidelines for disordered eating and other related behaviors.
4. Pediatricians should know when and how to monitor and/or refer patients with eating disorders to best address their medical and nutritional needs, serving as an integral part of the multidisciplinary team.
5. Pediatricians should be encouraged to calculate and plot weight, height, and body mass index (BMI) using age- and gender-appropriate graphs at routine annual pediatric visits.

6. Pediatricians can play a role in primary prevention through office visits and community- or school-based interventions with a focus on screening, education, and advocacy.
7. Pediatricians can work locally, nationally, and internationally to help change cultural norms conducive to eating disorders and proactively to change media messages.
8. Pediatricians need to be aware of the resources in their communities so they can coordinate care of various treating professionals, helping to create a seamless system between inpatient and outpatient management in their communities.
9. Pediatricians should help advocate for parity of mental health benefits to ensure continuity of care for the patients with eating disorders.
10. Pediatricians need to advocate for legislation and regulations that secure appropriate coverage for medical, nutritional, and mental health treatment in settings appropriate to the severity of the illness (inpatient, day hospital, intensive outpatient, and outpatient).
11. Pediatricians are encouraged to participate in the development of objective criteria for the optimal treatment of eating disorders, including the use of specific treatment modalities and the transition from one level of care to another.

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

- Early detection, initial evaluation, and ongoing management can play a significant role in preventing eating disorders from progressing to a more severe or chronic state.
- Rapid and aggressive medical stabilization and nutritional rehabilitation of patients with eating disorders will optimize short- and long-term outcomes.

### POTENTIAL HARMS

#### Refeeding Syndrome

Of particular concern is the refeeding syndrome that can occur in severely malnourished patients who receive nutritional replenishment too rapidly. The refeeding syndrome consists of cardiovascular, neurologic, and hematologic complications that occur because of shifts in phosphate from extracellular to

intracellular spaces in individuals who have total body phosphorus depletion as a result of malnutrition. Recent studies have shown that this syndrome can result from use of oral, parenteral, or enteral nutrition. Slow refeeding, with the possible addition of phosphorus supplementation, is required to prevent development of the refeeding syndrome in severely malnourished children and adolescents.

Single-episode Educational Programs

Single-episode school programs aimed at making changes in the cultural approaches to weight and dieting issues (e.g., 1 visit to a classroom) are clearly not effective and may do more harm than good. Additional curricula are being developed and additional evaluations are taking place in this field.

## QUALIFYING STATEMENTS

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

It should be noted that most medical test results will be normal in most patients with eating disorders, and normal laboratory test results do not exclude serious illness or medical instability in these patients.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

### IOM DOMAIN

Effectiveness
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Identifying and treating eating disorders. Pediatrics 2003 Jan;111(1):204-11. [78 references]

## ADAPTATION

Not applicable: The guideline was not adapted from another source.

## DATE RELEASED

2003 Jan

## GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

## SOURCE(S) OF FUNDING

American Academy of Pediatrics

## GUIDELINE COMMITTEE

Committee on Adolescence

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

American Academy of Pediatrics (AAP) Policies are reviewed every 3 years by the authoring body, at which time a recommendation is made that the policy be retired, revised, or reaffirmed without change. Until the Board of Directors approves a revision or reaffirmation, or retires a statement, the current policy remains in effect.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatrics (AAP) Policy Web site.

Print copies: Available from American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

## AVAILABILITY OF COMPANION DOCUMENTS

None available

## PATIENT RESOURCES

None available

## NGC STATUS

This NGC summary was completed by ECRI on May 15, 2003. The information was verified by the guideline developer on June 9, 2003.

## COPYRIGHT STATEMENT



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